Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

IMAGE MEDICAL CENTER
1415 Hwy 6, Suite 400-D
Sugarland TX 77478

Respondent Name
WAUSAU UNDERWRITERS INSURANCE

Carrier's Austin Representative Box
Number 01

MFDR Tracking Number
M4-13-0279-01

MFDR Date Received
September 25, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary taken from the request for reconsideration letter: "*…The rational [sic] for the denial was 'please provide explanation of CPT code 99080 for payment.' Firstly [sic] as everyone knows the CPT code 99080 refers to 'special report.' Secondly, as clearly and visibly indicated on the face of the HCFA for this medical bill was for a special report requested by DWC. Please refer to DWC rule 134.120(f)(5)(A) & 134.120(g)…"*

Amount in Dispute: $100.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…The charge of 99080 on dos 08/15/2012 has been processed. Payment of $50 was issued in check #025468075 on 09/21/2012. Reviewing report that was attached per DWC 134.120 narrative report is as 'Narrative reports are defined as original documents explaining the assessment, diagnosis, and plan of treatment for an injured employee written or orally transcribed and created at the written request of the insurance carrier or the Division. Narrative reports shall provide information beyond that required by prescribed medical reports and/or records'. Report does not meet definition of narrative report. We feel that the provider has been sufficiently reimbursed for services and no additional payment is required…"

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 15, 2012	99080	$100.00	$ 50.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 amended to be effective May 31, 2012, *37 Texas Register 3833*, applicable to medical fee dispute resolution requests filed on or after June 1, 2012, sets out the procedures for

resolving a medical fee dispute.

2. 28 Texas Administrative Code §134.203 sets forth the medical fee guideline for professional services.
3. 28 Texas Administrative Code §134.120 describes reimbursement for medical documentation.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanations of benefits (EOB)
   - 150(B327) – please provide explanation of CPT code 99080 for payment. Identify if report is for DWC069, DWC073, copy of records, or progress report.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
   - 45(Z710) – the charge for this procedure exceeds the fee schedule allowance
   - 217(Z559) – reimbursement has paid in accordance to the Texas Division of Workers Compensation rules, chapter 129 rule
   - W3 – additional payment made on appeal/reconsideration

Issues

1. Did the respondent raise a new issue?
2. Did the requestor receive appropriate reimbursement? Is the requestor entitled to additional reimbursement?

Findings

1. In its response to medical fee dispute resolution, the respondent states "…Reviewing report that was attached per DWC 134.120 narrative report is described as 'Narrative reports are defined as original documents explaining the assessment, diagnosis, and plan of treatment for an injured employee written or orally transcribed and created at the written request of the insurance carrier or the Division. Narrative reports shall provide information beyond that required by prescribed medical reports and/or records'. Report does not meet definition of narrative report…"

   Applicable 28 Texas Administrative Code §133.307 (d)(2)(F) states, "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review." No documentation was found to support that the respondent presented this denial reason prior to the request for MFDR. For that reason, the carrier's position regarding "Report does not meet definition of narrative report" shall not be considered in this review.

2. The medical documentation submitted supports a two-page report. 28 Texas Administrative Code §134.120 *Reimbursement for Medical Documentation*, states at (f)(5)(A) that the reimbursements for medical documentation are narrative reports: one to two pages--$100. The respondent indicated in their response that a payment of $50.00 was made. The requestor was contacted and verified that a payment of $50.00 had been received. Based upon the documentation submitted, additional reimbursement in the amount of $50.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $50.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to

$50.00 additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $50.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		March , 2013
Signature	Medical Fee Dispute Resolution	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.